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ABSTRACT

A five-month ethnographic study of conversations in a Philadelphia nursing home revealed some of the rules governing situationally appropriate conversational behavior. The social communicational perspective of the study differed from both psychological and discourse analysis approaches. Analysis of the data indicated that sustained resident/resident and resident/staff conversations were rare, that male/female resident contact was discouraged by staff members and feared by female residents, and that staff/patient conversational relationships centered around three broad nursing home-related topic categories. In addition, patients' discussion of personal topics was legitimated in only a few types of situations, discussion of personal lives by both residents and staff appeared to be appropriate only in the beauty parlor or physical therapy rooms, and in most situations there appeared to be normative sanctions against residents asking "personal" questions of staff or visitors. Staff members overtly excluded patients from their own conversations, citing residents' lack of interest in the types of topics staff members discussed--an observation contradicted by the researcher's own observations of residents' interests. It appeared that both residents and staff were subject to slightly different but complementary rules that produced the patterns noted. (GT)

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"Who Pushed the Button to Drop the A-bomb?": Contexts and Conversations in a Nursing Home

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The answer to the question posed in the title is, of course, Harry Truman. The question was originally asked of me by several female residents of a nursing home where, for five months last year, I was engaged in ethnographic field work. Although several nurses were nearby the residents when they began discussing the topic, the question was eventually asked of me when the residents' memories had given out. As later analysis showed, this was not an uncommon phenomenon at People's Home (which I am using as a pseudonym for the nursing home). Residents were extremely hesitant about discussing certain topics with most members of the staff, and staff were observed on more than one occasion to be actively discouraging certain conversations. I would like to make the initial suggestion that being elderly, and more specifically, that being elderly in an institutional context, involves mastery of rules for appropriate communication behavior. Furthermore, adherance to or deviation from these rules has consequences for definitions of status and the like which are accorded the residents by other institutional members. For the residents of the nursing home reported in the present paper, going about getting an answer to the question, "Who pushed the button to drop the A-bomb?," required knowledge of the interaction privileges and obligations of residents and staff vis-a-vis each other, and of the physical and temporal locations which permitted or encouraged or proscribed certain conversations and conversational topics.

In this paper, then, I would like to discuss some of the data derived from a larger study concerned with the manner in

which face-to-face conversation possesses infracommunicational patterning. I am concerned with conversation as one rule-governed component of communication which contributes to and, at the same time, is constrained by social structure.

The goal of the original research was to study the social "shapes" of conversational topics. By this is meant the structural linguistic concern for behavioral occurrences, co-occurrences, non-occurrences and non-co-occurrences, as governed by the "context of cultural reality" (Malinowski, 1965). It is assumed that, out of an array of available discourse topics, interactants tend to utilize only a sub-set of these topics for any particular conversation. In addition, it seems that few topics appear repeatedly across all conversational situations. This is to say that, despite the apparently unlimited potentials for conversational content, not all combinations of topics, or topics and situations, are ever employed (or, perhaps, are ever employable) in conversations which actually take place. As one ethnomethodologist notes, topics may be seen to be "warranted" in some fashion by the occasion of the talk in which they are contained (Adato, ms.). Similarly, Birdwhistell (pers. comm.) has suggested that there exist social-level boundary conditions which limit the flow of information across different sectors of society, and, in this manner, establish rules which shape, if they do not always fully determine, conversational content. On the interpersonal level, Hymes (1974) has recently expressed the view that communicators possess skills for handling topics to supplement their linguistic

(or grammatical) knowledge - i.e., communicative competence. Consistent with these writers, the present paper suggests that communicative patterning of behavior exists beyond the level of phonology, morphology or syntax, and that, on the level of discourse, rule-governed characteristics of topic or message content are discernible.

Earlier in this century, anthropologist Firth suggested that conversation be viewed in its cultural frame; he insisted that everyday conversation is and can be profitably studied as highly structured and patterned. He wrote:

> Speech is not . . . "boundless chaos." . . . For most of us the (social) roles and the (verbal) lines are there, and that being so, the lines can be classified and correlated with the part and also with the episodes, scenes and acts. Conversation is much more of a roughly prescribed ritual than most people think (1967:67).

Concerns similar to these have recently emerged as one of several research foci of sociolinguistics, the ethnography of communication, and social communication theory. Susan Ervin-Tripp hypothesizes, for example, that "one might . . . find that there are rules for topic selection just as there are for address" (1972:243), and suggests, along with other sociolinguists, that these rules are discernible when particular behavior is examined within the continuous, multi-channel context of which it is an element. Students of context analysis in communications also view the importance of topic patterning. For example, Scheflen writes that:

> In a given kind of conversation certain topics may be forbidden but there will be some number of allowable topics. All of those which do occur without disrupting the progression constitute a set of allowable alternatives. We sometimes

> say that these are allomorphic or equivalent at this level. Our task is to discover the allowable or at least the usual range of alternatives (1973:333).

This social communicational perspective must be distinguished from a psychological or individual-interactant approach to behavior. It is intuitively evident that the interests, motivation and education of speakers all play some part in determining what serves as a conversational topic in specific conversations (e.g., the appearances or non-appearances of topics in specific conversations). In 1945 Bossard commented on the wide range of topics that appear in conversations across families but the narrow scope of those talked about in any one family by writing that "one cannot escape the conviction that the range is determined . . . by their (i.e., individuals') predilections" (1945:235). Similarly, social psychologists such as Moore (1922), Landis and Burtt (1924) and Landis (1927) thought that by examining what men and women talk about researchers can gauge the "natural" differences in inclinations or interests of the two sexes. These atomistic perspectives on interaction are countered by data derived from conversation viewed as a form of <u>social activity</u> (cf. Malinowski, 1965). When viewed from "above," i.e., from the level of the social institution, endogenous or intra-individual explanations no longer suffice. Without denying the importance of the idiosyncratic to particular conversations, I would like to suggest that various aspects of the social situation (e.g., the participants' social relationship, their definition of the

discourse situation, the physical co-presence of non-participating others) may be seen to constrain the choice and maintenance of "appropriate" and/or "meaningful" conversational topics within a given speech community. It is these latter social concerns, as they are associated with topic boundary conditions, which are taken as central to the present study.

I would also like to distinguish briefly this social communicational perspective from a discourse analysis approach. Topic as a specific investigable component of speech behavior has figured only recently in research efforts directed toward the analysis of conversation and communication. As late as 1976, Keenan and Schieffelin remark that ". . . there has been no systematic study in linguistics on the way in which topics are initiated, sustained, and/or dropped in naturally occurring discourse" (1976:1). The resulting research in topic negotiation provides a syntax for the sequential organization of topics in discourse - i.e., given statement A, what techniques are employable by speakers so that statement B will be seen (1) as a development and maintenance of the first topic, (2) as a transformation or temporary termination of that topic, (3) as a reintroduction of an earlier topic, and so on. These writers are concerned with the rules facilitating talk on any set of topics, not specifically those which are socially permissible. Thus, they fail to consider that, in many cases, part of the interactional "work" that goes into the creation, sustaining and/or dissolution of a topic, is the degree to which

the topic itself is an expected, unexpected, rule-abiding or norm-breaking act within a larger social context framework. For example, I frequently observed the female residents at People's Home switching conversation to remarks about someone's new hair style or the friendly nature of the beautician at around the same time that another topic, usually an inappropriate reference to someone's health, was precipitating a confrontation among the speakers. A topic negotiation researcher would only be concerned with how speakers "managed" the transition from one topic to the next. I am suggesting that, in addition to this, the student of communication must examine those potentially volatile topics which may require transitions in certain contexts, and the topics which may appropriately serve this transition function. In brief, my research is concerned with some of the rules governing situationally appropriate topic appearances and non-appearnces at People's Home, rather than in the abstract system of rules generating "any" topic.

The data for this report are provided by an ethnogrphy of communication methodology as independently suggested by Birdwhistell (1977) and Hymes (1974). The ethnographic approach was chosen because of its traditional concern for the analysis of behavior within the larger social/symbolic context of production. During the five-month period of January through May 1978 I hand-recorded conversations between residents, staff and visitors in a private, ethnically heterogeneous nursing facility in Philadelphia. At the same time, observations of

other social activities were being performed, as well as detailed questioning of residents and staff. Taken together these various data enabled me to align conversations with different social activities, physical locales, interpersonal relationships, and so on. In this manner, the data generated by ethnographic observation and interviewing are that of conversations and conversational topics as part of and related to everyday social life at the institution.[1]

People's Home is located in an affluent, northwest suburb of Philadelphia. It is a modern, ranch-style facility, with the oldest wing built in the early 1960s and with the latest wing completed some time in 1975. The building is set back from the main road some thirty yards; it is surrounded by a thick woods on two sides and by a brick wall on the fourth side which separates the building from a neighboring psychological institute. Since most of my research took place during the winter, residents rarely left the building (and, incidentally, received very few visitors). The total number of residents fluctuated throughout my visits, but, on the average, there were about 150 at any one time. Most of the conversations described here took place in the main living room, the adjoining dining room, or a combination beauty parlor/physical therapy room on one of the wards. For reasons to be described below, most of the data are derived from observations of the female residents' conversations.

Before I discuss the communication rules which appear to guide the conversational topics at People's Home, it is

necessary to examine briefly rules for the presence or absence of talk altogether. It is true that this more likely points up the research question of when talk at People's Home exists at all, i.e., is "slotted" to occur. Nevertheless, the interest in the contexts of talk makes it somewhat difficult to divorce talk topics from this related question.

Dell Hymes (1974), among others, has suggested that speech is not everywhere valued equally, and that appropriate contexts for the appearance of talk must be discerned for specific speech communities. The residents of People's Home report that states of sustained talk, both with fellow residents and with staff members, are rare, and my observations seem to support these claims. While I never actually timed any of the residents, I would posit that the residents spent no more than 20 minutes in talk on any one day. Less impressionistically, I should point out that, during the first three or four weeks of field work, I found myself recording such journal entries as: "there has been continuous silence for the past hour"; "exchanges never consist of more than two or three utterance lengths"; and so on.[2]

With regard to talk with other residents, one eighty-year-old woman said to me: "People don't talk very much. . . . Sometimes we have the silent treatment; we don't keep up a running conversation. Then we just blurt out, and we know everything's all right." Interestingly, at one time or another during my field work, all of my principal informants relayed a negative evaluation to me on "excessive" amounts of talk.

Residents expressed pride in the fact that, if they had nothing to say, they did not feel compelled to keep up running conversations within their small circle of friends. Furthermore, these residents made a point of telling me that only the senile patients "sit and talk every hour," and that not everyone at People's Home was "fit" for talking with anyway.

With this last point, the female residents were specifically referring to the men. It should be pointed out that there were two related, but distinguishable, attitudes about the males held by the female residents and staff members. First, any sort of heterosexual coupling was discouraged at People's Home - even husbands and wives slept in different rooms and usually on different wards. The staff would often joke among themselves if they repeatedly saw the same man and woman eating a meal or sitting in one of the lounges together; they would usually chide the female resident about this, which usually had the effect of breaking up the pair. Most social activities seemed to have been designed to attract the women and left the men complaining that there was nothing for them to do - punch parties instead of card playing, gardening instead of baseball, and so on.

Secondly, the women feared the men. Approximately 50 percent of the male residents were service veterans and former patients at the V.A. psychiatric hospitals. The women repeatedly told each other stories about these men and actively avoided face-to-face contacts with them. Women who were seen talking to the men, other than the occasional exchange of an

hello, were ignored by the others; they were labelled as either "loose" or "in the head."[3]

The members of the staff population were also subject to convention with regard to the presence or absence of talk. For example, one nurse commented on the scarcity of talk between staff members and residents by noting that many of the conversational topics usually exchanged by the staff were no longer of any interest to the institutionalized elderly. These conversations included talk about recent newspaper items and things outside of the Home. Residents in turn seemed to avoid talk with ward and kitchen staff because of the limits on talk topics they tacitly felt being assigned and because they were anxious about breaching the rules. One rationalization they used was that the staff was too busy (even when on break) to be stopped for a moment or two of conversation. This all turned out to be somewhat ironic because staff members would frequently stop me in order to talk about my research progress, newspaper headlines, etc., whether they were on duty or on break. Also, residents would frequently want to talk with me about my home life, events occurring outside the institution, and events in history such as the dropping of the A-bomb; topics which no longer interested the residents, according to the staff.

In brief, female residents limited their talk to only the few individuals on the "safe" wards whom they knew; they rarely spoke with male residents or residents they hadn't been introduced to. Talk with the staff members usually occurred

in the context of their work routines, although I will note below that certain non-task exchanges did also take place.

I would now like to turn to a more specific description of conversational topics and contexts at People's Home. I will limit the discussion for the most part to talk between residents and staff.

As noted, brief verbal exchanges characterized all but a few of the residents' interactions with members of the staff population. These exchanges most often transpired when one or both participants were in transit from one location in the nursing home to another.[4] Analysis of the informant interviews revealed that residents prided themselves on having friendly relations with staff members, albeit through brief talk. Staff-patient conversational relationships were seen initially to involve talk on three broad topic categories.

(1) Events transpiring simultaneously within the immediate context, such as waiting to be served a meal, might be employed as a discourse topic.

(2) Closely related to this first one were references to deviations from expectations or "normal operations" within this immediate context. For example, if a resident or staff member was seen in a section of the Home they did not usually visit (and it should be pointed out that residents generally remained within a very narrow range of their bedrooms) or if their clothing was inappropriate for the time of day, these occasioned brief statements by either or both parties.

(3) The role relationship of the staff member and patient

often provided both participants with a range of assumed-to-be-held-in-common experiences which could serve as a topic, e.g., food with a cook, or gardening with activities personnel.

These exchanges[5] seem to represent what Malinowski called phatic communion - ". . . a type of speech in which ties of union are created by a mere exchange of words" (1972:151); very little "new"information appears to be being offered. Unlike the behavior discussed by Laver (1975) in his reformulation of the concept "phatic talk," I should note that these exchanges between residents and staff served as "ends" in themselves and rarely developed into lengthier conversations.

While the specific comments that were being expressed by the residents and staff at any one time on the above topics appeared to be in "free variation," closer examination of the data revealed that all topics under these circumstances were specifically related to Home life and activities. Except for brief occasions for "personal" talk to be described in a minute, most talk between residents and staff related to people and events inside the Home. As I will suggest throughout this paper, staff-patient interactions at People's Home appeared to be guided by a selection rule limiting verbal content to in-Home topics for all but a few situations.

I use the term "personal topics" to refer to talk about family, private feelings, professional careers and life experiences prior to retirement and/or institutionalization, etc. To some extent the staff and patients shared different levels of

knowledge about each other or these topics. The latter usually provided more talk about themselves than did the former, who adhered to nursing school canons of not sharing personal talk with patients.[6] Residents claimed that the work schedules of the staff personnel established boundary conditions (although, of course, they did not use that term) for the frequency and duration of interactional encounters with them. At the same time, they begrudged the staff members for frequently standing near the nurse's stations engaging in informal talk while they (the patients) looked on.

Analysis of the transcripts revealed that only three social situations legitimated talk by the patients on personal topics. First, it was not uncommon for patients to ask staff to make telephone calls for them, or to change a dollar bill for a long distance call. In return for these services, or while these services were being rendered, residents would provide an "account" or explanation for the interruption in the staff person's work routine. This account usually consisted of a reference or two about the family member being called.[7]

Introductions of relatives to staff members also occasioned "family talk." I would like to read a brief extract from the field notes which (I think) is paradigmatic of what I am referring to. A disclaimer is first required. The "relative" to be introduced and talked about in this example was me, by a woman who strategically claimed to be my aunt in order to help me in an assumed business venture. Mrs. Karp had previously misunderstood my reasons for being at the Home, assuming that I was

selling magazines to work my way through college.

> (After dinner, in Mrs. Karp's room in "A" wing:) One of the practical nurses comes in. She says hello and then cleans up the spillings on Mrs. Karp's dinner tray. The latter introduces me as her nephew "who goes to college with a scholarship." The PN says that that is very nice, and that god should bless all of the children and provide good education. She gives Mrs. Karp a piece of bread which she asked for. After the PN leaves, Mrs. Karp tells me that she had to lie about my being her nephew, that it was the only way for me to be successful (i.e., with the magazine selling).

Clearly, other analyses of this particular interaction could be proposed, especially in light of the fact that Mrs. Karp was rarely observed receiving family visitors. She did always tell me that she really knew that I was not her nephew. Nevertheless, her decision to treat me as a relative during the five months of my research established protocol for how she was to conduct talk with staff about me.[8] (Parenthetically, it should be pointed out that when staff brought their relatives, usually children, into the Home for a visit, they were introduced only to other staff members, not to patients.)

Extended discussion of one's personal lives (by both residents and staff) appeared to be appropriate in only one physical location at People's Home: the beauty parlor/physical therapy room. This was one of the few places where usual ward authority was not operable and the staff members (2 physical therapists and a beautician) encouraged "self-disclosure." Although I cannot as yet be sure of the significance of this, this was one of the few places at the nursing home where I noted continual tactile contact between the

residents and staff. As one resident said about the room: "It's just like a beauty parlor on the outside. All the women yakking away."

In most other situations at People's Home there appeared to have been normative sanctions against asking questions of the staff that might have been too "personal." In response to my question as to whether she ever spoke with staff, Esther Feigenbaum said: "Sure I do, certainly. (But) you can't get fresh with them because they have the upper hand." Residents whom I was able to rely on as informants uniformly noted that it was those other residents "who aren't well," "who are senile" or "who (just) don't know any better" who asked inappropriate questions of the staff.

This rule was even intended as operable for conversation with me. On one occasion, several patients and staff people were sitting around a television in one of the ward lounges after a special luncheon. One of the patients turned to me and asked: "So, who do you belong to? Who's your girlfriend?" While I blushed at first, I was willing to tell her some of the details of my private life, just as I had spoken about these with other patients and with staff. The recreation director quickly turned to the resident, however, and said, "Gloria, you know you're not supposed to ask those questions," and to me, "You don't have to answer her, y'know." After the party had completely disbanded, one of the other residents came up to me to apologize for her wardmate, by stating that "she really didn't know what she was saying," and so on.

During my visits to People's Home this rule was enforced whenever staff members were around, but it was considerably relaxed when the residents and I were alone, perhaps sharing a snack in the living room or a meal in the dining room.[9] Interestingly, this same procedure was followed with other non-family repeat visitors. For example, People's Home received weekly visits from a group of novices. Conversation between the novices and residents was considerably animated on those wards where staff members were on break or at their stations, but where staff was present, more time was spent singing.

For contrast, I would now like to discuss staff-to-staff conversations which occurred in the physical co-presence of residents. At People's Home it is not uncommon to find staff engage other staff members (and visitors) in talk about events and personalities removed from the Home, and for this to be done with the apparent exclusion of co-present patients. Often this takes on a particularly harsh tone by overtly noting to the patient the exclusiveness of both the conversational relationship itself and the specific topic under relationship control. For example:

> (4:00 p.m. In the living room:)
> Mrs. Kern's nurse was talking to Fred, with Mrs. Kern holding on to her nurse's arm. The following indicates the extent to which Mrs. Kern was not being included in the conversation:
> Kern: I didn't hear that.
> Nurse: He's not talking to you. Stop listening. He's talking to me.
> Kern: What did he say?
> Fred: I'm not talking to you, baby. I'm talking to this woman.

In one conversation which is too lengthy to reproduce here,

4 residents and 3 staff members were sitting around a large game table stuffing envelopes. Staff members were overheard to engage each other in talk about: (1) a recent visit to a nearby private botanical garden; (2) boyfriends; and (3) roommates while at college and since getting a job. The three staff members were sitting next to each other, and had their postures and eye gaze oriented only to each other. Within the larger interaction, however, the only talk between the residents and staff centered around: (1) getting more envelopes; (2) who was going to stamp the envelopes; and (3) what the best technique was for stuffing the envelopes.

I later questioned the three staff members on their reasons for apparently not also talking to the patients about their "outside" adventures. All three agreed "(the old people) are not interested in that kind of talk any more."

What I find especially interesting about all of this is that the residents showed much interest throughout the study in engaging me in talk about events the staff said no longer interested them. Patients often came to me (and a few other visitors like myself) regarding events in recent history or general "common knowledge" items they had forgotten. In addition, I was frequently asked (and responded) about recent book, movie and theatre releases, and about my opinions on then current topics in the news (e.g., recent outbreaks of the Legionnaire's Disease, the University of Pennsylvania employee firings, and so on).[10]

It may be appropriate at this juncture to introduce the

useful concept of "participation status" developed by Goffman (1974). Participation status may be defined as the social definitions of one's fellow interactants with regard to their assumed level of interactional contribution, especially the capacities and privileges they may enjoy in a particular communication relationship. Conversational and topical exclusions apparently are two behavioral means employed by staff for defining the communication participation status of the residents. On numerous occasions, the staff were recorded as saying: "It's not that we do it purposely, it's just that they (the residents) wouldn't be interested (in those conversations or topics)." There is a social definition of residents as no longer concerned with most affairs of the outside world, and this serves the staff as an appropriate guideline for not sharing these topics with them. In turn, residents apparently do not attempt to join any of the staff-staff and staff-visitor conversations they are excluded from; we might say that they have accepted a definition of themselves as non-equal participants and as not "interested" in these topics (at least, when not talking among themselves or with me).

The gerontology literature may shed some light on why the residents adhere to this convention. First, several students of institutional life propose that a social context, such as a nursing home, in which all major life services are performed for the patient breeds social withdrawal and passivity in the individual (cf. Lawton, 1970). Secondly, Goffman (1961) points out that inmates of total institutions

try to avoid coming up against the tacit rules for appropriate behavior by withdrawing from any conduct that might be seen as sanctionable. These are obviously theoretical speculations which require further exploration. What I think is shown in the present data is that the residents' behavior adhered to a series of social conventions when interacting with members of the professional staff. These ruleswere relaxed to some degree in talk with outsiders such as myself and in the beauty parlor/ physical therapy context. Conversely, the staff members attributed an across-the-boards disinterest by elderly individuals in many topics, and so made no active attempts to include them in certain levels of talk. Thus, no one group at People's Home was "at fault"; both populations were subject to slightly different but complementary rules which produced the pattern described above.

We have seen that boundaries for the permissible "penetration" of certain topics may develop in institutional contexts and that social relationships may be defined or constituted by these boundaries. Precisely why the patterns surrounding such a question as "Who pushed the button to drop the A-bomb?" exist the way they do at People's Home, and like institutions, is difficult to know at present. The larger social importance of the above topic rules must await further ethnographic contrastive studies. A tentative orientation may be proposed, however.

The process of aging cannot be described as a return to infancy from a physiological point of view solely; it must also be understood in terms of a social context which provides a

support system for the elderly members. In addition, there is what sociologists call a "career path," which is the set of social experiences - behavioral and attitudinal - which lead individuals to placement or "careers" in various institutional contexts. Thus, the larger ethnographic present for the conversational patterning discussed above must consider that entry into a nursing home is usually shrouded in family and staff expectations for future social behavior by the elderly patients. These include expectations about participation in social activities, heterosexual friendships, and so on. The boundary conditions which apparently foreclose on talk on outside-Home events between staff and patients may be related to a number of such social assumptions about entry into and life within a total institution, especially one such as People's Home in which the usual exit is provided by death only. Thus, this analysis of rule-governed behavior is only a first step to further work: the place of rule-governed behavior within the larger social life.[11]

NOTES

1. A strict content analysis scheme which would have coded each transcribed dialogue into a limited and mutually exclusive set of topics, was not employed. Instead, each dialogue was analyzed according to as many of the manifest and latent references made by the speakers as were discernible. A similar approach is suggested by Rutherford, et al. (1970).

2. In order not to foreclose prematurely on the corpus through an a priori definition, a wide degree of latitude was ultimately permitted with regard to what would be considered a "conversation." States of prolonged verbal contact among residents, or between residents and staff, were extremely rare at People's Home, as they are in many institutions reported in the gerontology literature (cf. Carmichael, 1976), and so it was necessary to examine the content of all manner of talk - passing greetings, chit-chat, dinner time talk, service requests, and so on.

3. I was also discouraged by the women from staying with the men; their fears, coupled with resistance I met from several male residents, explain why most of the data are derived from female conversations.

4. In fact, most talk which was not directly concerned with staff's instrumental tasks took place in the main living room or on the ward corridors. Residents complained that staff members would often walk into their rooms without uttering a word, needless to say, without offering an apology.

5. Some examples:

(12:00 noon. The residents are sitting around the tables in "A" lounge, waiting for lunch.) One of the janitors enters. He is very bouncey, and my subjective reaction is that he "livens up" all the others:
Janitor: How are you doing, baby?
Ellen: Are you going to eat?
Janitor: Yep, I got me a appetite, baby.
. . . .

(In "A" lounge, after lunch:)
A nurse's aide who usually works on "C/D" walks by with a tray.
Mrs. Raymond: Why, hi, what are you doing here?
Aide: They mixed up the trays.
Raymond: Oh, well. I thought they shipped you over here.
Aide: No, not yet. How're you?
Raymond: Fine, thank you.
Aide: Good. Well, bye.

(Interview with Frances Smith:)
SJS: What do you talk about with the kitchen people?

Smith: There used to be this Black cook named Teddy. When he'd be leaving at night, I used to tell him about how good the birthday cakes were. He used to tell me I was so easy to cook for.
SJS: What do you talk about with Sheila or Carol? (the activities personnel)
Smith: Carol gave me a purple passion plant. You see. (She points to the window.) I have a sunny window. It's grown all the way up to the window. So when she passes by I call her in to cut it. And every now and then I call her in to look at it, and she's always asking me how it's doing.

6. The nurses obviously possessed more channels of information retrieval than did the patients - including the patients' files and informal conversation with the patients' families.

7. For example:

("B" wing nurse's station:)
Mary Lyons: (Holds up a piece of paper with some numbers on it.) Will you dial for me? I can't stand up to reach it.
Aide: Sure. (Comes from behind the desk.)
Lyons: Thank you. Y'know, I used to be a telephone operator, worked the switchboards for the telephone company here in Philadelphia.
Aide: Yeah.
Lyons: Yeah.

8. A less "dramatic" example:

(Near "E" nurse's station:)
Lucy Fischer: This here is my brother.
Nurse: Hi, how're you?
Brother: Fine, thank you. Lucy was just telling me -
Fischer: He's gonna take me home today.
Nurse: Oh, that's nice of you.
Fischer: Yeah. He works for the department of (?), and he got some time off.

9. Note a new staff member being cued into these rules:

Dietician: He asked me if I'm married, and if I go to school.
Nurse: He don't know any better, really.
Dietician: Really, I didn't mind.
Nurse: Well, you're better off not getting too friendly, y'know.

10. Perhaps I was fulfilling a necessary social function for the institution. On several occasions, the recreation director commented about my "social visits" with residents by noting that it was having such a positive effect. She noted that, as

a result of my visits, it was possible for more of the residents to engage in some conversation during the day with "outsiders" since the recreation staff was otherwise too small to accommodate such extended interactional frameworks.

11. Goffman writes:

> In a total institution . . . minute segments of a person's line of activity may be subjected to regulations and judgments by staff; the inmate's life is penetrated by constant sanctioning interaction from above, especially during the initial period of stay before the inmate accepts the regulations unthinkingly (1961:38)

And, Gustafson writes:

> Although no staff member or relative will directly discourage the patient from making new friends . . . , he is often not expected or encouraged to do so. . . . Admission to the home is usually treated as the end of one's useful social career (quoted in Marshall, 1975: 1130).

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